



Human Resources and Talent Management

Families First Coronavirus Response Act

Leave Request Form

Email: Leave@gcpsk12.org • Fax: 678-301-6111 • 437 Old Peachtree Road, NW, Suwanee GA 30024-2978

Name _____ Employee ID # _____
(First) (MI) (Last)

GCPS Location _____ Position _____ Supervisor Name _____

Contact Number _____ Personal E-mail Address _____

Families First Coronavirus Response Act (FFCRA) – Emergency Paid Sick Leave Act (EPSLA) – Emergency Family and Medical Leave Expansion Act (EFMLEA)

An employee is entitled to take leave related to COVID-19 if unable to work because of the following. Please choose **ONE** option. Documentation is required and subject to continuous review. Provisions will apply through December 31, 2020.

Up to two weeks, or a maximum of 80 hours, or a part-time employee's two week equivalent, of paid sick leave may be applied if approved for one of the following reasons:

- Subject to a Federal, State, or local quarantine or isolation order related to COVID-19;**
- Advised by a healthcare provider to self-quarantine related to COVID-19;**
- Experiencing COVID-19 symptoms and seeking a medical diagnosis.**

Salary will continue at 100% up to 80 hours or a salary maximum of \$5,110, and is not deducted from your GCPS leave balance.

Provide the name, address, and contact information for your health care provider (required):

- Caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID19; or caring for an individual who has been advised by a health care provider to self-quarantine related to COVID-19;**

Salary will continue at 2/3 of your regular salary up to 80 hours, or a part-time employee's two week equivalent, or a maximum of \$2,000, and is not deducted from your GCPS leave balance.

Provide the name, address, and contact information for the health care provider of the individual whom you are caring for (required):

- Experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services;**

Salary will continue at 2/3 of your regular salary up to 80 hours, or a part-time employee's two week equivalent, or a maximum of \$2,000, and is not deducted from your GCPS leave balance.

Provide the name, address, and contact information for your health care provider (required):

- Caring for a child whose school or place of care is closed due to COVID-19 related reasons, and no other suitable child care options are available.**

Salary will continue at 2/3 of your regular salary up to 12 weeks of paid sick leave up to a maximum of \$12,000, and is not deducted from your GCPS leave balance.

Provide the name, address, and contact information for the school or place of care which your child attends or at which your child is registered, that is closed due to COVID-19 related reasons (required):



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(First) (MI) (Last)

Requested Leave Start Date

Indicate the beginning date of the period of which you are requesting to be off of work. A spreadsheet will be emailed to your GCPS email address, that you will be required to update and submit to Leave@gcps.k12.org.

Signature and Certification

Failure to follow leave guidelines may result in loss of all rights and privileges provided under current policy. If the request is determined to be fraudulent or documentation does not support your request, the approval will be revoked. Any changes in your request must be submitted, in writing, to the Leave Administration Office.

I certify that all information on this form is correct and subject to medical review. By signing this form, I release medical information to GCPS, based on the name of the healthcare provider(s) mentioned above.

Please do not enter requested time on a timesheet or through the Employee Portal. All approved time is processed in the Division of Human Resources and Talent Management.

Employee's Signature: _____ Date: _____

If additional information is required, you must provide to the Leave Administration Office within three calendar days of the request.

-----To be completed by Human Resources Leave Administration -----

FMLA eligible? YES / NO

Comments:

Beginning Date of FFCRA _____ Leave schedule / duration / period of me: _____

Leave Administration Signature: _____ Date: _____